

FMLA Notification Letter



Date:

To:

Address:

From:

This notice is to inform you that beginning on _____, your leave is being designated as leave under the Family and Medical Leave Act (FMLA) of 1993.

In accordance with the FMLA, Rule 5-Section 508 of the City's Personnel Rules & Regulations Manual provides that employees may take up to 17 workweeks per calendar year of FMLA leave for the following reasons: (1) the birth and care of a newborn child or the placement of a child with you for adoption or foster care; (2) to care for your spouse, domestic partner, child, or parent with a serious health condition; or (3) a serious health condition that makes you unable to perform the functions of your job.

Please refer to Personnel Rule 5, Section 508 and the Administrative Memorandum: Family & Medical Leave Act of 1993 in the City's Personnel Manual for the complete policy and further restrictions.

Enclosed is the City of Tempe's Family and Medical Leave Act Notice of Employee Rights and Obligations. This notice contains an explanation of your rights and obligations under the Family and Medical Leave Act of 1993 and the City's leave policies. Also enclosed is a Family and Medical Leave Request form. Please complete the form by indicating the projected length of your leave, the reason for your leave, and whether the leave will be continuous or intermittent and return it to your supervisor.

Depending on the reason for your leave, if you have paid leave benefits, these may overlap with your FMLA leave. Under the City's policy, if you are eligible to take medical and/or vacation leave, you must use this leave and it will count towards the total 17-workweek entitlement. After your paid leave is exhausted, the remaining time of your leave will be unpaid.

Please refer to Rule 5, Section 503 of the City's Personnel Manual for the City's policy on eligibility for, and use of, accrued medical leave.

- If your leave is due to your own serious medical condition or that of a family member, also enclosed is a Certification of Health Care Provider (Family & Medical Leave Act of 1993) form. Please have your physician complete this form. You must return this form to your supervisor within two weeks.
- If your leave is due to your own health condition, upon your return to work you must submit a fitness for duty release from your physician, which indicates your ability to perform the essential functions of your job with or without reasonable accommodation.

After you have read the enclosed information, if you have any questions or concerns, please call your supervisor, department's assigned Human Resources analyst, or Deputy Human Resources Manager Jon O'Connor at 350-8423.

Enclosures (2)

FMLA Notice of Employee Rights & Obligations
FMLA Request Form